

New Generations

Spring 2016



Photo taken at NHC Healthcare, Maryland Heights

<http://health.mo.gov/seniors/nursinghomes/providerinfo.php>

On the Road...to Culture Change

By Sam Plaster, State Culture Change Coordinator

In early August 2015, I attended the national culture change conference hosted by the [Pioneer Network](#) in Chicago, Illinois. During one of the training sessions, someone asked if nursing homes could keep live chickens. I couldn't think of any home that did or any regulations that prohibit it. Shortly thereafter, I sat next to NHC Maryland Heights (NHC) Administrator Susan Taylor at the state culture change coalition ([MC5](#)) regional meeting in St. Charles. Ms. Taylor shared that NHC had chickens and many other animals. I wasted no time scheduling a visit later that month.

Ms. Taylor and Director of Nursing Jeff Loraine showed colleague Leslie Sebastian and I around.

Ms. Taylor has been administrator for the past 12 years and started as an intern. Mr. Loraine has worked here 12 years. The two believe consistent, stable staffing is a significant contributor to their success. NHC staff members generally stay about six years, and the home maintains a 93 percent to 94 percent occupancy rate.

We barely passed through the front door when we noticed a true sign of home, a resident napping on a couch in one of the living areas.

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Over the years, NHC has made several physical changes to deinstitutionalize, including replacing the old nurses' stations with a living area, a kitchenette and small work areas. Residents still share rooms, but real walls divide the rooms rather than curtains to enhance resident privacy. Walls have had the added benefit of reducing falls. If residents become unbalanced, they can steady themselves by reaching out to the wall rather than a curtain that provides no support.

The home has added a new family dining room/ theater, complete with cable TV and surround sound. They also have a large library, dedicated in memory of former employee Burnice Taylor, with Internet access. Residents can also enjoy alcoholic drinks in the bar.

A real highlight of NHC is the resident animals, which began living here in 1995 and prompted a visit by a Missouri lieutenant governor. They include chickens, fish (indoors and outdoors), birds, Spice the sheep, Gracie and Sheila—the alpacas— and Cocoa the horse. One resident even has “Cocoa” tattooed on his shoulder. Another resident has a fish bowl hanging from his ceiling to view the fish while lying in bed. NHC used to have goats but had to get rid of them because they were climbing on the roofs. The chickens roamed free in the courtyard until a hawk began to eat them. Now they are confined in small coops.

The home has six outdoor areas. Residents also have a raised garden to grow vegetables. Residents' families are an integral part of NHC life, and they, along with staff members, painted a wooden courtyard fence to make it more pleasing. The home also added taller chairs outside to aid residents in sitting or getting up. The result? Residents spend even more time outdoors.

The home has a big fireworks show on Independence Day, and decorations abound year-round to celebrate

other holidays and festivities including 30 trees at Christmas.

Meals at NHC are prepared by an executive chef and are served restaurant style. Soup and salad accompany every meal, and ice cream is always available in the ice cream parlor.

We ran into Dr. John Morley in the courtyard. Dr. Morley has been with NHC since 1990 and also works for St. Louis University. He brings students, researchers and doctors from Hong Kong and China to the home to learn about the home's programs and has travelled to Singapore to share those programs.



Left to right: Administrator Susan Taylor, Director of Nursing Jeff Loraine, and Dr. John Morley

One research program featured St. Louis University collaborators who combined cognitive stimulation therapy with exercise. Residents who participated had better memory, and a decrease in negative behaviors and antipsychotic medication. The results were published in the [Journal of the American Medical Directors Association](#). NHC received a Quality Improvement Award from the American Medical Director's Association for the program.

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NHC has the largest dementia special-needs neighborhood in St. Louis. It's called "The Meadows." Dr. Morely is especially proud of the Snoezelen room, which provides multi-sensory stimulation therapy for individuals with dementia, and said the home plans to add to it.

We visited with 88-year-old resident Earl "Obie" Obermoeller, a lifelong St. Louisan. His father worked for a packing company and his mother was a housewife. At 17, Mr. Obermoeller received consent from his mother to join the U.S. Navy during WWII. He served on two ships; the USS Quapaw, a seagoing tug that rescued other ships; and, a destroyer, the USS Dempsey.

After the war, he attended business school and then worked for Laclede Steel until he retired at 59. He said, "Retirement is great. If you can do it, take it." He and his wife had three daughters and a son who died at 17. Mr. Obermoeller showed us a small wooden ship in his room that he built to help cope with his son's death.



Lydia VonJohn and Earl "Obie" Obermoeller

Mr. Obermoeller introduced us to his "lady friend," Lydia VonJohn. Friends for more than 50 years, they became closer after their spouses died. Staff welcomes Ms. VonJohn and asks about her when she isn't here. "She greets them and slaps me," he said.

Nurse Holly Hamilton, a restorative coordinator, has worked at NHC 15 years. A mother of two, she enjoys spending time with her husband, a chef and caterer, fishing, and playing piano.

She says NHC has changed over the years. They used to put everyone to bed and put up the side rails, then they got everyone up at a certain time. Now, they start assessing individual needs even before a person moves in. For example, if a person likes to knit, they are going to have all kinds of knitting stuff for that person. "We have accomplished meeting residents' schedules."



*Restorative Coordinator
Holly Hamilton, LPN*

NHC has a creed: "The Better Way." During each morning meeting, the home focuses on one of the 20 creed promises, such as "escort you to your destination." "We don't point and say 'that way,'" Ms. Hamilton said. "We escort them." Each month, the home has a group meeting with staff and residents, and residents let NHC know if it fails to live up to any creed promise.

Ms. Hamilton said she has never seen an administrator as involved as Ms. Taylor. "Susan listens and is fair to everyone. She is not afraid to do anything. She passes trays and even does incontinence care. I honestly love her and Jeff."

One of Ms. Hamilton's family members moved in for short-term rehabilitation and said NHC didn't feel like a nursing home.

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In 2004, Ms. Hamilton's coworkers rallied to her aid when she was diagnosed with multiple sclerosis and could not work for three months. During her absence, they paid all of her bills and the dietician sent food for her children every day.

CNA Cynthia Johnson, originally from Caruthersville,

Missouri, has worked at NHC seven years. Her three daughters volunteer here. They, serve refreshments, go for walks with residents and help with activities.

Ms. Johnson said, "The Meadows is the best neighborhood in the building. That's because I'm back there." Though the residents live

with dementia, they are still in charge. "They get up when they want. If you wake them up, they aren't happy. Some like to sit and talk; others like to fold laundry, sweep or serve juice." Ms. Johnson includes

residents in her work schedule so they feel needed. "Some might not say a word, but I can communicate with them. You have to put yourself on their level."

She loves to cook and has made residents cookies, brownies, taquitos, quesadillas, fish, chili dogs, spaghetti, and tacos. "They eat more when I cook, and food is the best way to keep them happy," she says. The only complaint she receives is "not making the coffee fast enough in the mornings."

Recently, the residents' families showed their appreciation for Ms. Johnson by throwing her a birthday party. Of course, the celebration included residents.

Ms. Johnson also takes trips with the residents. Recently they visited Administrator Taylor's home and were treated to hot chocolate by Ms. Taylor's children. That type of family orientation is the biggest improvement Ms. Johnson has seen at NHC. While we were talking, she pointed to two staff members hugging and said, "See that?"

She is protective of the residents and says she lets the administration know if a new employee is not a good fit. "We have to have the right people with the right mindset. If their heart is truly in the right place, things go well."



CNA Cynthia Johnson

Fighting the Tide that is Dementia, Hand-in-Hand

By: Wendy Boren, BS, RN, QIPMO Clinical Educator/Consultant

For those taking care of someone with dementia, every day is like fighting the tide. There may be peaceful moments and calm waters when life seems to be drifting along gently. A few seconds later, water crashes on the rocks.

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A person caring for someone in the early forms of dementia can be caught in that tide of reality and confusion. The person they care for may be able to use the restroom, walk, and have short conversations; but, 30 minutes later, that person will repeat the same thing over and again. Caregivers then find themselves hiding the car keys and locking the door.

The middle stages of dementia are worse. Many caregivers have the most difficult time in this stage. Their loved ones or residents can become aggressive, suffer profound memory loss, have a miniscule attention span and appear to be floundering in the waves. At this stage they have lost more than they understand and cannot comprehend why. They still feel deeply and yet they often don't know why they feel the way they do. Caregivers are often at a loss as to what to say and how to say it. Their loved one or resident often changes in ways they do not recognize and it takes an emotional toll. People in the middle stages of dementia are often still strong, so physical threats to a caregiver are often an unexpected reality.

For caregivers, the last stages of dementia are often the most physically taxing. They must often provide total physical care to the loved one or resident, who has little or no interest in eating, is often incontinent, more withdrawn, and may be non-communicative. Caregivers often describe this stage as simply caring for a shell; the person inside has already withered up and gone. Hand-in-Hand training can help.

In 2010 Congress passed the Affordable Care Act. The act includes a Centers for Medicare & Medicaid Services training for CNAs, nurses, and other healthcare providers, specifically geared to care for residents with dementia. The focus is on person-centered care, making it valuable to anyone in a caregiver role. The course has six modules, which take 6 to 8 hours to complete.

Hand-in-Hand training begins with a basic introduction and physiology of the brain. A few of the most common types of

dementia are explored and radiographic examples illustrate how dementia takes over the brain. In my teaching, I include "The Brain Tour" from the Alzheimer's Association. The tour helps explain why people who have dementia or Alzheimer's disease may



have certain long-term memories and sensory connections, but not short-term ones. I also spend time discussing each type of dementia. A stroke, for instance, may prompt vascular dementia in someone who previously showed no signs of dementia.

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The training also focuses on communication and action-reaction techniques. Real-life videos get to the heart of what we experience every day in our homes and caregiving settings. Simple scenarios such as waking people up, giving them baths, dining or having general conversations with them, and dispelling fears and anxiety are all featured with person-centered interventions. Hand-in-Hand training also makes us examine ourselves so that we can better understand our residents. In other words, the training reminds us to be a human being first, and a clinician second. If we can master this feat, our quality of life and our residents' quality of life will be better. The training asks:

What are *your* strengths and weaknesses?

What does home mean to *you*?

What is something people don't know about you?

Those questions may sound simple. But if we understand who *we* are, we begin to look past people's diagnoses and at the people themselves. A person's core does not change because of dementia. For example, by understanding that Mrs. Jones always had an aversion to mashed potatoes, we will avoid serving them to her five times a week, though the food fits our idea of a pureed diet. Or, if Mr. Smith always enjoyed gardening and being outdoors, a walk outside with him might be the perfect way to dispel pent-up frustration. And for the Mrs. Howells of the world who always enjoyed music? Why not have them listen to an iPod with their favorite ragtime song as they spend hours in their geri-chairs? Perhaps they are unable to connect in any way other than a smile when they hear "The Entertainer."

Finally, Hand-in-Hand training looks at abuse. Someone with dementia may feel lost and threatened and perceive certain actions as abusive or neglectful—though we may not—but may be unable to express their feelings. Hand-in-Hand training teaches staff to recognize these situations and ways to prevent, report, and handle them.

I've taught Hand-in-Hand training in high school CNA classes, as orientation to nurses, to CNAs, housekeepers, and administrators, to social service clubs in the community, and to family caregivers. It is a simple, relevant tool that actively engages participants and focuses on finding the person inside the diagnosis. By knowing our residents and taking the time to care for them on an individualized basis, we offer so much more than "caregiving." We offer them life, with its ebb and flow, and, after all, isn't that the point?

Feel free to contact me with any questions at wborenrn@gmail.com.



Prioritizing Individuals Who Will Benefit From Antipsychotic Reduction

By: Sharon Thomas, BSN, RN, RAC-CT, QIPMO Educator

Atypical antipsychotic drugs are being overprescribed for elderly residents with dementia in long-term care, and the side effects include an increased risk of death. Though the FDA includes that warning in a black box about the drugs, a 2011 Office of Inspector General (OIG) report found a high percentage of Medicare claims for such drugs in elderly nursing home residents with dementia. The report is available at oig.hhs.gov/oei/reports/oei-07-08-00150.pdf.

The OIG report prompted the Centers for Medicare & Medicaid Services (CMS) to launch a National Partnership to Improve Dementia Care and Reduce Unnecessary Antipsychotic Drug Use in Nursing Homes in 2012.

Atypical antipsychotics are often prescribed for elderly persons with dementia to manage their symptoms. In addition to the OIG, the use of antipsychotic medication for the management of behavioral symptoms has come under fire by many geriatric professionals. The management of symptoms by non-pharmacologic means is being encouraged and is showing positive results.

As part of the effort to decrease the use of antipsychotics in nursing homes, the partnership is working to provide resources to improve services for non-drug dependent persons with dementia. CMS developed the Hand-in-Hand Toolkit. The training material, mailed to every U.S. nursing home, emphasizes person-centered care. The kit contains training modules that focus on communication, abuse prevention, and high-quality care for elders. The modules, which include video clips, are intended to help care partners develop the necessary skills to work with persons who have dementia and to help each individual maintain a high quality of life. Those

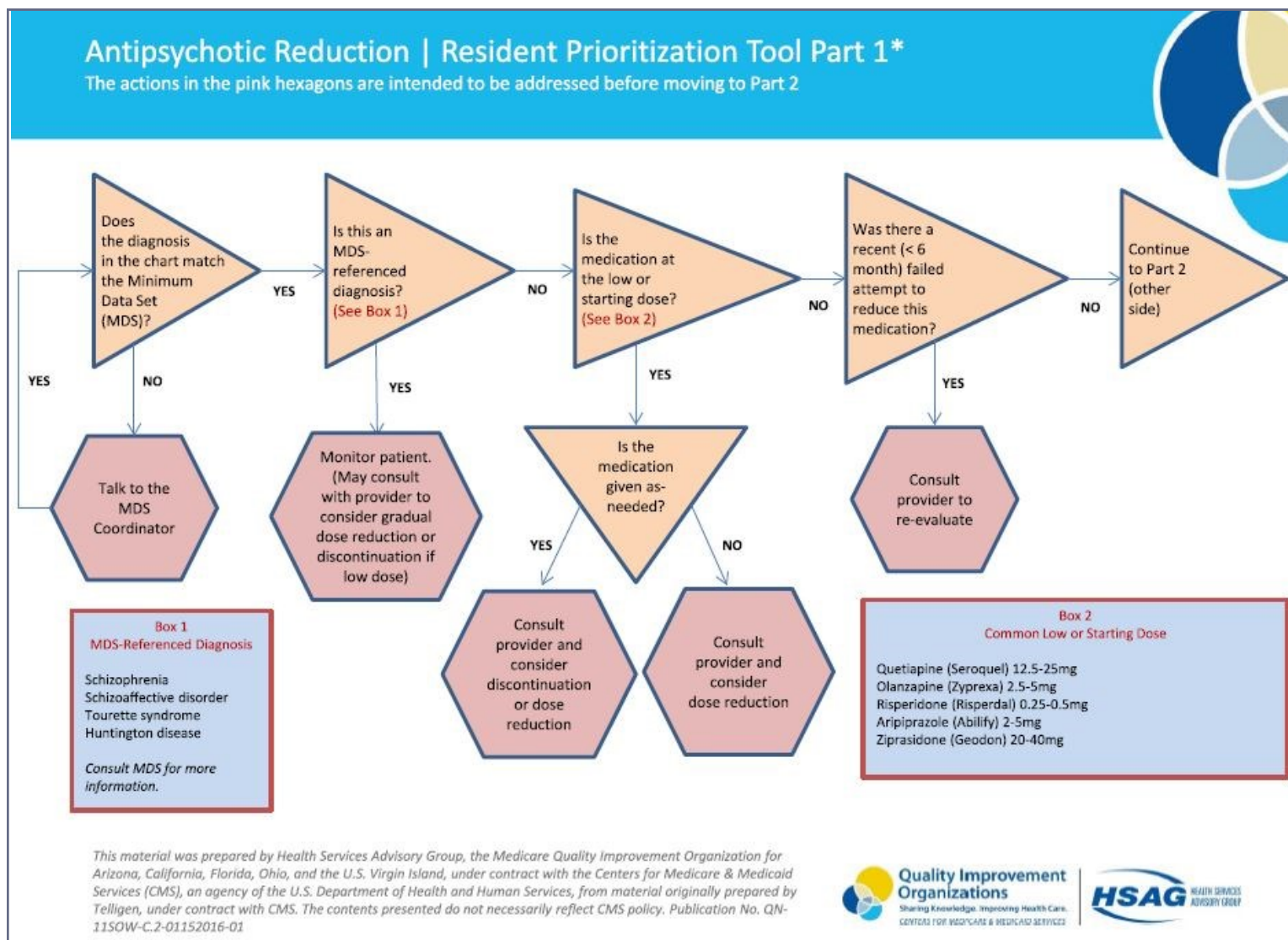
who cannot find their Hand-in-Hand Toolkit can download it at www.cms-handinhandtoolkit.info/Index.aspx.

CMS also emphasizes the use of non-pharmacological alternatives for residents. Examples of non-pharmacological interventions include consistent assignment, increased activities, the Music and Memory program, art therapy, or better management of pain. Any approach must be individualized and tailored to the current needs of each resident. Interventions must be recorded in care plans and updated as needed.

The most recent data from the partnership details progress. Nationally, in 2011Q4, 23.9 percent of residents in long-stay nursing homes received antipsychotic medication. In 2015Q3, the percentage decreased to 17.4 percent. In Region 7, which includes Kansas, Iowa, Nebraska, and Missouri, the rate dropped from 24.5 percent to 18.8 percent. Missouri's rates went from 26 percent to 19.33 percent, a reduction of 26 percent. Despite this drop, Missouri is 39th in the nation for antipsychotic usage. The data comes from the CMS Quality Measure data based on the Minimum Data Set (MDS) 3.0 assessments. Those with a diagnosis of schizophrenia, Huntington disease, or Tourette syndrome are excluded from the measure. It should be noted that the Quality Measure does not reflect gradual-dose reductions, which are often necessary to safely eliminate a medication from an individual's medication regime. The MDS only shows if a person is taking a drug. That being said, many homes are actively working to decrease dosages with the ultimate goal of total elimination.

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The new “Antipsychotic Reduction, Resident Priority Tool” may also help reduce antipsychotic usage.

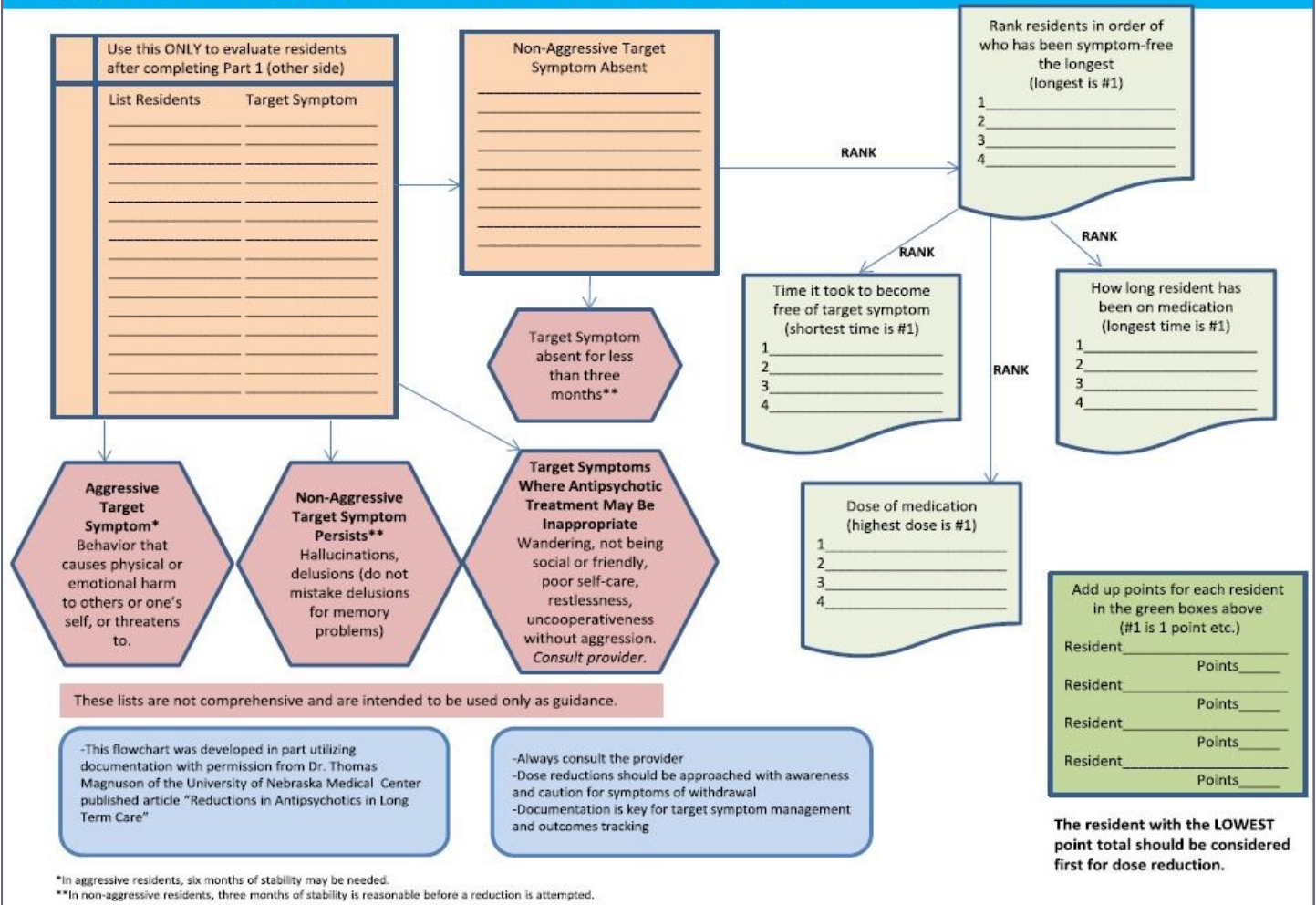


The tool was developed by Telligen, a Medicare Quality Innovation Network Quality Improvement Organization, under contract with CMS. The tool will help identify and prioritize individuals who should be considered for gradual dose reduction (GDR). Part 1 asks a series of questions that begin with ensuring the diagnosis in a chart matches the MDS. The next question reviews the dosage and administration schedule and assesses for attempts at gradual dose reduction. Part 2 provides a guide in determining the high-priority, gradual-dose reduction residents. Please look at the tool and consider how it can help your efforts at eliminating antipsychotic medications for residents with dementia in your home. It is available at www.hsag.com/contentassets/a94cac2292914df2bef9611b42c1f177/antipsychotic-reduction-tool_508pubbed.pdf.

Your QIPMO nurse is available to assist you in utilizing this tool and continuing your efforts to find non-pharmacologic methods to support residents who struggle with dementia. Remember that “problematic” behavior exhibited by residents with dementia may really be their way of communicating. As we learn to “hear” what residents are telling us, we will be better able to utilize their strengths to meet their desires and needs. This will enable them to live life to the fullest and will give staff a great feeling of satisfaction.

For more information on the partnership and survey guidance related to nursing home residents with dementia and unnecessary drug use, please review the S & C memo dated May 24, 2013.

www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/National-Partnership-to-Improve-Dementia-Care-in-Nursing-Homes.html



Through the Times... part II

By: Barbara Primm

Loch Haven Assistant Administrator Barbara Primm shares how the times have changed.

In my first blog, I spoke of starting my long-term care career as a four-hour-a-week consultant for Lakeview, the county home in Macon, Missouri.

The year was 1967. Macon County had formed a nursing home district, which eventually prevailed in getting a bond issue approved by voters to fund and construct Loch Haven, an 83-bed nursing home.

On a happy day in February 1970, we moved the 47 residents from the county “poor farm”, as Lakeview was called, into Loch Haven. The residents were delighted. Of course from our 2015 perspective, Loch Haven looked a lot like a hospital, but the roof did not leak, the windows were not cracked, every room had a bathroom stool and a sink. The furniture, curtains and bedspreads all matched. What could be better?

The remaining beds were quickly occupied. The waiting list was long. Local residents actually paid close attention to the obituaries reported on the radio station. If the family of a prospective resident heard of a death at Loch Haven, they called to see if they could rent the deceased resident's room. Vacancies often lasted less than a day. The board made the decision to add 20 more beds in 1974. Still, the demand was great. Another 17 beds in 1976 brought the bed total to 120.

Until 1975, Loch Haven was a “private pay” home, though some residents were eligible for the Division of Family Services’ “cash-grant” program. The residents’ increased financial needs prompted Loch Haven to join the Medicaid program in 1975, after the home met a requirement to install a sprinkler system.

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During Loch Haven's first five years, I worked part-time: teaching classes, filling in as a charge nurse, etc. My husband, a highway patrol trooper, and I had three small children (eventually five). A flexible schedule was very important to me and my family. Sometimes after my husband came home from work to be with the kids, I worked a partial shift at Loch Haven. I became more and more involved with the elders.

I had the privilege of learning the ropes gradually. First, state regulations. Then, with the addition of the Medicaid program, I had to learn the federal regulations. I take my hat off to all of you who had to learn state and federal regulations concurrently.

In 1979 I became a licensed nursing home administrator and was assistant administrator at Loch Haven.



Barbara Primm receiving her award and resolution for 41 years of service at Loch Haven from administrator Byron Freeman.

By 1980, there was “no room at the inn” and Loch Haven considered getting into the Medicare Part A program. Until then, we had been licensed for intermediate care only.

In 1983 Loch Haven and I took some big steps. I added director of nursing to my title. Loch Haven's new 60-bed addition was licensed as a skilled nursing home and could accept Medicare Part A and Medicaid.

What a challenge! Parts of Loch Haven resembled a hospital. At one point we had 20 residents who were being fed by enteral feeding tubes. We had a long-term ventilator-dependent resident. Then Medicare imposed the Prospective Payment System (PPS) on hospitals. We commonly refer to it as DRG, the acronym for Diagnoses Related Groups. The result was that hospitals wanted to move elders out as quickly as possible, and Loch Haven was the recipient agency.

While our staff continued to provide great care, looking back, there is no doubt we were providing staff-directed care and fitting residents into our schedules. I am pretty sure the same can be said of almost every nursing home in the 1980s. The culture in long-term care had changed with the move from the old dilapidated buildings to new modern buildings.

Staff education had improved. Nursing assistants had to be certified. Missouri was a pioneer in establishing a state-approved curriculum for certified nursing assistants. I was fortunate to be part of a committee that first developed the curriculum, as well as one for certified medication technicians.

Generally, the care provided was clinically sound but often did not consider residents' preferences.

One of the landmark movements that focused on residents' preferences and safety began in the mid-80s: the “Untie the Elderly” program. I attended a seminar on the topic in Jefferson City. The presenters—a nurse and administrator—came from Kendal, a Pennsylvania nursing home. Though I knew the topic and agenda prior to attending the seminar, I smugly thought that the Pennsylvania nursing home didn't use restraints because its residents were different from ours. At that time, about 40 percent of our residents used some form of restraints.

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Let me digress a moment. At the opening of Loch Haven, we did not use restraints. Our residents, though frail, were mostly able to walk. Hospital stays were long in the days before DRGs. The very sick and frail were mostly in our hospitals.

As the years went by, however, the inevitable age-related decline occurred. We had weaker residents. The staff felt it was doing the right thing by using a draw sheet to secure a resident in a chair, a bed, or even on the bathroom stool or commode! When John Posey began to manufacture all types of restraints, Loch Haven was one of the best customers. The manufactured restraints seemed so much nicer than the draw sheets!

I was probably sitting with my mouth open at the seminar as I watched the screen and realized the Kendal residents were, indeed, just like ours. Fortunately I had all of Loch Haven's unit supervisors with me; I never could have convinced them of the benefits of restraint-reduced homes had they not attended the seminar. We were all excited about the restraint-reduction process and chatted all the way home about the residents that we intended to start "untying." In a matter of weeks, we went from about 40 percent of our residents using some type of

restraint to 10 percent or 15 percent. Of course today that number is 0 percent to 3 percent! A state surveyor at the time told me it frightened her to see so many frail elderly walking, but she knew if she were in their shoes, she would want to have the same opportunity.

Also, during the 1980s, many for-profit corporate nursing homes sprang up across the United States. This was probably related to the implementation of the Prospective Payment System in hospitals. While some corporate homes were very good, others used minimum staffing for maximum profits, which resulted in poor care. Some not-for-profit homes tried to keep costs too low and did not provide good care. All across the nation, those operators gave the entire long-term care industry a black eye.

The bad actors in the industry were exposed by various advocacy groups and, in 1986, the Institute of Medicine did a landmark study and report of the status of long-term care in the United States. The findings indicated very poor care in many homes and led to the Nursing Home Reform Act in 1987, often called OBRA '87. It is the source of all our regulations today.



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